

DEPARTMENT OF HEALTH AND HUMAN SERVICES  
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 10/22/2013  
FORM APPROVED  
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>155446</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____  B. WING _____		(X3) DATE SURVEY COMPLETED  <b>C</b> <b>10/02/2013</b>
NAME OF PROVIDER OR SUPPLIER  <b>COVINGTON MANOR HEALTH AND REHABILITATION CENTER</b>			STREET ADDRESS, CITY, STATE, ZIP CODE <b>5700 WILKIE DR</b> <b>FORT WAYNE, IN 46804</b>		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE	
F 000	<p>INITIAL COMMENTS</p> <p>This visit was for the Investigation of Complaints IN00136296 and IN00136792.</p> <p>This visit in conjunction with the Post Survey Revisit (PSR) to the Investigation of Complaints IN00134671, and IN00135403.</p> <p>This visit was in conjunction with the PSR to the Investigation of Complaints IN00131980, IN00132305, and IN00132735.</p> <p>Complaint IN00136296 Substantiated. No deficiencies related to the allegations are cited.</p> <p>Complaint IN00136792 Unsubstantiated due to lack of evidence.</p> <p>Survey Dates: September 29, October 1, &amp; 2, 2013</p> <p>Facility number: 000476 Provider number: 155446 AIM number: 100290870</p> <p>Survey team: Christine Fodrea, RN</p> <p>Census bed type: SNF/NF: 118 Total: 118</p> <p>Census payor type: Medicare: 24 Medicaid: 69 Other: 25 Total: 118</p>	F 000			

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE

(X6) DATE

Any deficiency statement ending with an asterisk (\*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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F 000	Continued From page 1 Sample: 5  Covington Manor Health and Rehabilitation Center was found to be in compliance with 42 CFR Part 483, Subpart B and 410 IAC 16.2 in regard to the Investigation of Complaints IN00136296, and IN00136792.  Quality review completed on October 12, 2013 by Randy Fry RN.	F 000			